ABERDEEN AREA YOUTH REGIONAL TREATMENT CENTER

Residential Admission Form Section I

Client Demographic Information

To be completed by counselor.

Client Information					
Name:					Date:
Address:			City, State & Zip Code:		
Date of Birth:	Age:	Sex:	Male Female	Social Security #:	
Home Phone:		Religion:			
Tribal Affiliation:					
Emergency Contact					
Name:			Relationship to Client:		
Address:			City, State & Zip Code:		
Home Phone #:			Work Phone #:		
Referral Source:					
Name:			Program Name:		
Address:			City, State & Zip Code:		
Phone #:			Fax #:		
Parent/Guardian Information					
Mother's Name:					
Address:			City, State & Zip Code:		
Home Phone #:			Work Phone #:		
Date of Birth:			Tribal Affiliation:		
Father's Name:					
Address:			City, State & Zip Code:		
Home Phone #:			Work Phone #:		
Date of Birth:			Tribal Affiliation:		
Health Care Coverage					
IHS Service Unit:				Phone #:	
Eligible for Contract Health Services? YES NO		Name & Phone # of IHS/ CHS Authorizing Official:			
Medicaid (welfare)? YES NO	Medicaid #:		State Medicaid filed in:	Eligibility Date:	

ABERDEEN AREA YOUTH REGIONAL TREATMENT CENTER

Residential Admission Form Section I

Client Demographic Information

To be completed by counselor.

Private Insurance? YES NO	Insurance #:		Name of Insured:
Relationship to Client:		Name of Insurance Company:	
Address:			City, State & Zip Code
Phone #			Fax #:
Why does the client need residential treatment?			

ABERDEEN AREA YOUTH REGIONAL TREATMENT CENTER

Residential Admission Form Section II

Substance Use History

Biomedical Conditions (Medical Problems and Physical Challenges):	
Allergies: Medications _____ Foods _____ Insect Stings _____ Plants _____	**NOTE: Doctor statement required for allergies, bee stings and reasons for medications.** Other:
Does the client have a history of: Asthma _____ Seizure Disorder _____ Heart Problems _____ Diabetes _____ Tuberculosis _____	Other medical problems:
What medications are currently prescribed for the client?	
Is the client physically challenged? Does the client use a wheelchair, crutches, cane? Does the client have vision or hearing difficulties? YES NO	If "YES", please explain: _____

Emotional/Behavioral Conditions and Complications:					
Has the client seen a psychiatrist, psychologist, or counselor for emotional or mental problems? YES NO	IF "YES", please explain: Therapist's Name	Phone #	Dates of Treatment	Reason for Therapy	
Is the client currently in outpatient treatment? YES NO	If "YES", describe frequency and regularity of visits:				
Does the client have a history of suicide thoughts or attempts? YES NO	If "YES", please describe the situation(s) to include how and with what they tried to harm themselves:				
Was the client hospitalized? YES NO	Date	Methods	Name of Hospital	# of Days in Hospital	Substance Abuse Involved? YES NO
					YES NO
					YES NO
Does the potential resident currently have any suicidal thoughts? YES NO	If "YES", please describe:				
Does the potential resident currently have any homicidal thoughts? YES NO	If "YES", please describe:				

ABERDEEN AREA YOUTH REGIONAL TREATMENT CENTER

Residential Admission Form Section II

Substance Use History

Does the client have past or current legal problems? YES NO	If "YES", please describe:	
Does the client have a history of violent or assaultive behavior? YES NO	If "YES", please describe:	
Has the client been involved with a gang? YES NO	If "YES", which gang? Gang colors:	Describe the client's involvement with the gang:
Is the client court-ordered to treatment? YES NO	If "YES", please enclose a copy of the court order.	
Does the client have any symptoms of an eating disorder? These may be restricted food intake, excessive exercise, use of laxatives, binge eating, or vomiting. YES NO	If "YES", please describe:	
Client's height (without shoes):	Client's weight (without shoes):	
Does the client have a history of firesetting? YES NO	If "YES", please describe:	
Does the client have a history of problematic sexual behavior? YES NO	If "YES", please describe:	
Does the client have a history of learning problems (learning disability, special education, resource rooms, mental retardation)? YES NO	If "YES", please describe:	
Is the client pregnant? YES NO	If "YES", how many weeks pregnant? Location and Phone #:	Who is providing prenatal care for the client? When was the last prenatal appointment?

Treatment Acceptance/Resistance

Does the adolescent recognize their use of drugs or alcohol is a problem? YES NO	Please describe:
How do they describe their use of drugs and/or alcohol?	

ABERDEEN AREA YOUTH REGIONAL TREATMENT CENTER

Residential Admission Form Section II

Substance Use History

Relapse/Continued Use Potential:		
Is the client showing craving any drug-seeking behavior? YES NO	Has their use increased recently? YES NO	Please describe:
Has the client made attempts to control or cut down on their substance use? YES NO		Please describe:
If the client is *abstinent*, are they in a personal crisis and at risk of relapse? YES NO		Please describe:

Recovery Environment			
The following questions deal with whether the client's current environment is not supportive of recovery, is hazardous, or there are difficulties in the home that make it difficult to participate in treatment on an outpatient level.			
Please list the members of the client's family.	Family Member's Name	Age	Relationship

Who currently lives <u>in the home</u> with the client, other than family members? Please list their names, ages, and relationship to client:	Name	Age	Relationship

Is there any history of violence or domestic abuse in the home? YES NO	If "YES", please describe:
Is there anyone currently living in the client's home that is an active substance abuser? YES NO	If "YES", please describe:

ABERDEEN AREA YOUTH REGIONAL TREATMENT CENTER

Residential Admission Form Section II

Substance Use History

Is there anyone currently living in the client's home that is active in a program of recovery? YES NO	If "YES", please describe:
Does the client have any friends who are non-users of active in a program of recovery? YES NO	If "YES", please describe:
	Aftercare _____ AA/NA _____ Al-Anon _____ Alateen _____ Other _____
What type of support groups are available to the family?	Aftercare _____ AA _____ NA _____ Healing Through Feeling _____ Al-Anon _____ Alateen _____ Other _____
What are the current discharge plans for the client after treatment?	Living Situation: School/Work: Aftercare Program: Frequency of aftercare visits:

Additional Information

Is client's substance use at least of moderate severity?	YES	NO
Does client need an intensive program with a 24-hour structure?	YES	NO
Is client unable to control use despite active participation in less intensive care?	YES	NO
Is there a danger of physical, sexual, and/or severe emotional attached in the patient's current environment, which will make recovery unlikely without removing the individual from this environment?	YES	NO
Does the client experience difficulties in getting to outpatient treatment?	YES	NO
Has client's use increased in the last 6 months?	YES	NO

Referring Counselor's Signature: _____ Date: _____

ABERDEEN AREA YOUTH REGIONAL TREATMENT CENTER

Residential Admission Form Section II

Substance Use History

Substance (check all that apply)		Age of First Use	Date of Last Use	Usual Amount Used	Frequency of Use	Months/ Years of Regular Use	How Taken (see below)	Tolerance (Yes or No)	Withdrawal (Yes or No)
Alcohol:									
Beer/Coolers									
Wine									
Hard Liquor									
Cannabis:									
Marijuana									
Hashish									
Hash Oil									
Hallucinogens:									
LSD or "Acid"									
Peyote/Mescaline									
Psilocybin									
PCP									
Mushrooms									
Datura									
Other:									
Cocaine:									
Powder									
Crack/Freebase									
Opiates:									
Heroin									
Codeine									
Opium									
Synthetics									
Stimulants:									
Speed									
Crank/Crystal									
Ice									
STP, MDA, etc.									
Sedatives:									
Valium									
Librium									
Xanax									
Nicotine:									
Cigarettes									
Cigars									
Pipes									
Chew Snuff									
Snort Snuff									
Inhalants:									
Solvents									
White-Out									
Spray Cans									
Anesthetics									

Frequency of Use:	**1 = No use in the past month**	**4 = 2-3 times per week**	**7 = Continuous use**
	2 = Once a month	**5 = Once a day**	
	3 = Once a week	**6 = 2-3 times a day**	
How Taken:	**O = Oral**	**I = Injection**	**X = Other**

ABERDEEN AREA YOUTH REGIONAL TREATMENT CENTER

Residential Admission Form Section III

Medical Information

Medical		
Name of Physician:		
Address:		
Phone #:		
Date of last Physical Exam:		
Vision		
Name of Optometrist:		
Address:		
Phone #:		
Date of last Eye Exam:	Wears Contacts	Wears or needs glasses
Dental		
Name of Dentist:		
Name of Clinic:		
Address:		
Phone #:		
Date of last Dental Exam:		

Client's Signature	Date
Signature of Client's Interviewer	Date
Printed Name of Client's Interviewer/Title	Date

HISTORY AND PHYSICAL EXAMINATION
ABERDEEN AREA YOUTH REGIONAL TREATMENT CENTER

This form is to be completed by a licensed Physician, Physician's Assistant, or a Nurse Practitioner. A complete history and physical examination *needs to be completed within one month* prior to entering our treatment facility.

NAME:_____ DATE OF PHYSICAL:_____
DOB_____ M / F (circle one)

VITAL SIGNS: T____ P____ R____ B/P_____ HT._____ WT._____ (Both without shoes)

ALLERGIES: Yes No MEDICATIONS FOODS BEE STINGS OTHER
(circle all that apply) Explain Reaction:

VISON SCREENING R_____ L_____ corrected uncorrected

HEARING SCREENING R_____ L_____

REPRODUCTIVE FACTORS: G P LC SA TA

LMP

SMOKING: Y N PPD_____
CHEWING TOBACCO Y N

CURRENT MEDICAL PROBLEMS:_____

CURRENT MEDICATIONS & DOSE:_____

DRUG/ALCOHOL USAGE HISTORY:
(Circle all that apply) For how long?

Last Use?

	ALCOHOL	MARIJUANA	INHALANTS	PRESCRIPTION DRUGS
For how long?				
Last Use?				

OTHER STREEET DRUGS_____

LABS REQUESTED: CBC SMA-7 LFT'S UA HCG TSH RPR HEPATITIS PANEL (with A,B,C)
PLEASE ATTACH COPIES OF ALL LABS

PAST MEDICAL HISTORY F= Family S= Self					REVIEW OF SYSTEMS			PHYSICAL EXAMINATION		
YES	NO	F	S		NL	ABN		NL	ABN	
				Heart Disease			General			Appearance
				Heart Murmur			Skin			Skin
				Hypertension			Eyes			Eyes
				Diabetes			Ears			Ears
				Tuberculosis			Nose			Nose
				Asthma			Throat			Mouth/Throat
				Seizures			Mouth			Neck
				Cancer			Endo./Meta.			Thorax
				Hepatitis			Neuro.			Heart
				STD's			Musculosekeletal			Abdomen
				Kidney Disease			Blood/Lymph.			Extremities
				Athlete's Foot			Cardio.			Neuro.
				Mental Disorders			Respiratory			Psych.
				Hospitalizations			GI/Liver			Genitalia
				Surgeries			Kidney/Urol.			Spine/Scoliosis
				Any Prosthesis?			Psych./Soc.			Rectal
							Genitalia			Pelvic
							Breasts			Breast
							Gyn.			
							Other			

*REVISED 5/31/01
IHS MANUAL - CHAPTER 18
CARF - Section 4-C

GENERAL ASSESSMENT & PLAN:

Medical Diagnosis:_____

Plan:_____

_____

Any physical restrictions?_____

(NOTE: Approximate length of stay at our treatment facility *may* be three months or longer depending on this client's level of advancement. Please schedule any future CRITICAL appointments *before* treatment and other appointments *after* treatment.

☆ **COMMENTS:**

☆ **PLEASE ATTACH THE PPD FORM AND A COPY OF THE IMMUNIZATION RECORD**

_____ _____

(MEDICAL PROVIDER'S SIGNATURE & DEGREE) **(*PRINT* MEDICAL PROVIDER'S SIGNATURE & DEGREE)**

Name of Clinic/Facility:_____

Mailing Address:_____

City, State, Zip Code:_____

Phone # : (___)_____ Fax # : (___)_____

DEPARTMENT OF HEALTH & HUMAN SERVICES **Public Health Service**

Aberdeen Area
Youth Regional Treatment Center
PO Box 680
Mobridge, SD 57601-0680

TUBERCULIN SKIN TEST QUESTIONNAIRE

Name:_____ SS#:_____ D.O.B._____

Please answer the following questions about your health prior to your TB skin test. "Yes" answers indicate conditions that can cause false results on the TB skin test.

1) Have you ever had Tuberculosis or a positive TB skin test? Yes_____ No_____

2) Are you pregnant? Yes_____ No_____

3) Are you currently ill or running a fever? Yes_____ No_____

4) Have you received a vaccine in the last two months? Yes_____ No_____
(i.e., MMR, flu vaccine)

5) Have you had a viral infection within the last two months? Yes_____ No_____

TUBERCULIN SKIN TEST DATA

*****Please note that results for a TB skin test done within the last year are acceptable, *if* all the information requested below is available on that test result.**

TB SKIN TEST MUST BE READ WITHIN 48 - 72 HOURS OF PLACEMENT ON THE FOREARM. TESTS NOT READ AND RECORDED WITHIN THIS TIME WILL BE CONSIDERED INVALID.

TB skin test given on _____ _____ on the (circle one) R / L forearm
(date) (time)

Given by:_____

Skin test read on _____ _____ _____
(date) (time) (read by)

Redness? Yes_____ No_____ Induration? Yes_____ No_____

If induration noted; size in mm's_____

IHS-810 (4/03)
FRONT

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service

FORM APPROVED: OMB NO. 0917-0030
Expiration Date: 05/31/2006
See OMB Statement on Reverse.

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

COMPLETE ALL SECTIONS, DATE, AND SIGN

I. I, _____ *(Name of Patient)*, hereby voluntarily authorize the disclosure of information from my record.

II. The information is to be disclosed by:	**And is to be provided to:**
NAME OF FACILITY Aberdeen Area Youth Regional Treatment Center	NAME OF PERSON/ORGANIZATION/FACILITY (Parent)
ADDRESS PO Box 680	ADDRESS
CITY/STATE Mobridge, SD 57601-0680	CITY/STATE

III. The purpose or need for this disclosure is:
For continuity of care, to provide progress reports, discuss discharge, aftercare, and follow-up plans.

IV. The information to be disclosed from my health record: *(check appropriate box(es))*

- ☐ Entire Record
- ☐ Only information related to *(specify)* _____
- ☐ Only the period of events from _____ to _____
- ☐ Other *(specify)* _____
- ☐ **Psychotherapy Notes ONLY (by checking this box, I am waiving any psychotherapist-patient privilege)**

If you would like any of the following sensitive information disclosed, check the applicable box(es) below:

- ☐ Alcohol/Drug Abuse Treatment/Referral
- ☐ Sexually Transmitted Diseases
- ☐ HIV/AIDS-related Treatment
- ☐ Mental Health (Other than Psychotherapy Notes)

V. I understand that I may revoke this authorization in writing submitted at any time to the Health Records Department, except to the extent that action has been taken in reliance on this authorization, this authorization was obtained as a condition of obtaining insurance coverage or a policy of insurance, or other law provides the insurer with the right to contest a claim under the policy. If this authorization has not been revoked, it will terminate one year from the date of my signature unless I have specified a different expiration date *or expiration event*. _____
*(Enter if different from **one year after** date below)*

I understand that IHS will not condition treatment or eligibility for care on my providing this authorization except if such care is: (1) research related or (2) provided solely for the purpose of creating Protected Health Information for disclosure to a third party.

I understand that information disclosed by this authorization may be subject to redisclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act Privacy Rule [45 CFR Part 164], and the Privacy Act of 1974 [5 USC 552a].

SIGNATURE OF PATIENT	DATE
SIGNATURE OF AUTHORIZED REPRESENTATIVE *(State relationship to patient) or Witness (if signature is thumbprint or mark)*	DATE

This information is to be released for the purpose stated above and may not be used by the recipient for any other purpose. Any person who knowingly and willfully requests or obtains any record concerning an individual from a Federal agency under false pretenses shall be guilty of a misdemeanor (5 USC 552a(i)(3)).

PATIENT IDENTIFICATION

NAME *(Last, First, MI)*	RECORD NUMBER
ADDRESS	
CITY/STATE	DATE OF BIRTH

PSC Media Arts (301) 443-1090 EF

IHS-810 (4/03)
FRONT

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ADDRESS	ADDRESS PO Box 680
CITY/STATE	CITY/STATE Mobridge, SD 57601-0680

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CITY/STATE Mobridge, SD 57601-0680	CITY/STATE

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PATIENT IDENTIFICATION

NAME *(Last, First, MI)*	RECORD NUMBER
ADDRESS	
CITY/STATE	DATE OF BIRTH

AAYRTC Inventory Checklist for Males & Females

Name: _____ Date: _____, 2004

What to Bring:

_____ 4 – 7 shirts or t-shirts
_____ 3 – 4 pairs of jeans
_____ 2 – 3 pairs of shorts (must be knee length)
_____ 1 - stocking cap (seasonal)
_____ 1 pair of gloves (seasonal)
_____ jacket (seasonal)
_____ 5 – 7 pairs of socks
_____ 5 – 7 pairs of underwear
_____ athletic shoes
_____ shower shoes (**flip flops**)
_____ pajamas / slippers

***ALL CLOTHING SHALL NOT HAVE INAPPROPRIATE LOGOS: RELATED TO ALCOHOL, DRUGS, TOBACCO, GAMBLING, ANY SEXUAL CONNOTATIONS, AND GANG RELATED LOGOS.**

Personal Hygiene Products needed are:

_____ shampoo / conditioner
_____ comb/brush
_____ lotion
_____ toothpaste/toothbrush (need toothbrush cover)
_____ 3 –4 bars of soap / soap dish
_____ disposable razors
_____ deodorant (Non-aerosol)
_____ fingernail/toenail clippers

* **ALL PERSONAL HYGIENE PRODUCTS MUST BE ALCOHOL FREE (any product without content information will be put into resident's luggage and can not be used.)**

PLEASE DO NOT BRING ANY OF THE ITEMS LISTED BELOW

Cameras / radios/ tape or CD players
Pillows, blankets, towels, or stuffed animals
cologne / perfume
Any type of aerosols or hair sprays
Food, pop, gum, or seeds
Tobacco products
Makeup (females)
muscle shirts (boys)
bandanas
Hats are NOT allowed
Any type of jewelry (rings, earrings, tongue studs, etc.)
weapons of any kind
alcohol or drugs of any kind
over the counter medications
any type of glass item
mouthwash
skimpy /tight clothing (females)
bras with underwires **(the wires will need to be removed, if brought in.)**

Any pictures, drawings, or clothing with drug or alcohol, gambling, tobacco, or gang related logos or sexual connotations will be sent home or left in client's luggage.

NOTE to Referral source: This sheet may be reproduced and given to the family.